

Comparative Study

A Comparative Study on Guilt, Shame-Proneness, Impulsivity and Suicide Lethality between Men and Women who had Attempted Suicide

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ABSTRACT

Suicide, the deliberate act of ending one's life, contrasts with suicide attempts, where individuals survive the ordeal. Termed as "failed" or "nonfatal," these attempts are debated terminologically. Self-harm, a pressing public health concern, closely relates to suicide risk, inflicting profound psychological distress. Theoretical frameworks posit that distressing emotional states, particularly shame and guilt, drive self-harm. Notably, these emotions act as both instigators and outcomes in suicide attempts, warranting exploration. Empirical evidence consistently reveals attempted suicides outnumber completed ones, emphasizing the need for understanding contributing factors. Gender disparities are evident, with women exhibiting higher rates of nonfatal self-injury, suicidal ideation, planning, and attempts. This study employed an ex post facto design, drawing a purposive sample (N = 89) from Rajiv Gandhi Government General Hospital, Chennai, aged 20-55. Tools included the Guilt and Shame Proneness Scale, Barratt Impulsiveness Scale, and the Columbia Suicide Severity Rating Scale. Data analysis employed statistical tests and correlations, scrutinizing hypotheses. This comprehensive approach illuminates the intricate interplay of suicide attempts, guilt, shame, impulsivity, and gender.

Keywords: *Suicide Attempt, Guilt, Shame, Lethality, Impulsivity, Gender*

Suicide is a multifaceted phenomenon with devastating consequences for individuals, families, and societies worldwide. Suicide attempts, often characterized as nonfatal, provide a window into the intricate web of emotions and motivations that drive individuals towards self-harm. Among the myriad emotions intertwined with self-harming behaviors, guilt and shame emerge as crucial factors. These emotions can both instigate and result from suicidal thoughts and attempts, making them pivotal in unraveling the complex nature of this phenomenon.

Gender plays a significant role in the landscape of suicide. Research consistently demonstrates pronounced gender differences in suicidal thoughts, planning, and attempts.

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Societal expectations and norms further contribute to varying patterns of suicidal behavior among men and women. Understanding these gender-specific nuances is essential for tailoring effective suicide prevention strategies.

This study employs a robust research design to investigate the relationships between guilt, shame, impulsivity, and gender in the context of suicide attempts. By examining guilt and shame proneness, impulsivity, and suicide lethality.

METHODOLOGY

The current research employs a mixed-methods approach, encompassing content analysis, retrospective data analysis, and structured clinical interviews. A diverse sample of 89 suicide attempters, aged between 20 and 55 years, was selected from Rajiv Gandhi Government General Hospital and the Institute of Mental Health, Chennai. Data collection included translated versions of the Guilt and Shame Proneness Scale, the Barratt Impulsiveness Scale, and the Columbia-Suicide Severity Rating Scale. Statistical analyses incorporated means, standard deviations, t-tests, Cohen's d, Mann-Whitney U tests, Glass' Ranked Biserial correlations, and Spearman's rank-order correlations.

Need for the study

India, a vast country with a population of 1.37 billion as of 2019, grapples with a pressing issue - suicide. Every year, over one lakh (one hundred thousand) lives are tragically lost to suicide in our nation. Recent Indian literature reveals a concerning trend; suicide rates have surged during the decade spanning from 2005 to 2015, with a significant 17.3% increase. This rise is particularly pronounced in the southern and eastern states of India.

The gender dynamics surrounding suicide are noteworthy, with a male-to-female suicide ratio of approximately 2:1. Numerous theories emphasize the pivotal role of shame and guilt as strong predictors of self-harming behaviors in both men and women. Additionally, impulsivity is identified as a primary causal factor behind many suicide attempts. This underscores the intricate relationship between guilt, shame, and impulsivity, which can ultimately lead to self-injurious actions, sometimes resulting in tragic suicides. It's worth mentioning that previous literature has highlighted that nearly one-fifth of impulsive suicide attempters employ methods with the potential for fatal outcomes. In fact, 11.7% of these impulsive suicide attempts result in injuries severe enough to necessitate hospitalization. This statistic underscores the debilitating nature of impulsive suicide attempts.

The present study aims to assess the levels of guilt, shame, impulsivity, and suicide lethality among individuals who have attempted suicide, focusing on gender differences in these dimensions.

Tools used:

- **Guilt and Shame Proneness Scale:** This scale is designed to measure an individual's propensity to experience guilt and shame in various situations. It likely consists of subscales assessing different aspects of guilt and shame, such as negative behavior evaluation, guilt repair, shame-negative evaluation, and shame withdrawal.
- **Barratt Impulsiveness Scale (BIS):** The BIS is a widely used self-report questionnaire designed to assess impulsivity. It measures various dimensions of impulsivity, including attention, cognitive stability, motor impulsiveness, perseverance, self-control, cognitive

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complexity, and total impulsiveness. In your study, you focused on self-control as a dimension of impulsivity.

- **Columbia-Suicide Severity Rating Scale (C-SSRS):** The C-SSRS is a standardized assessment tool used to evaluate the severity of suicidal ideation and behavior. It helps in categorizing the lethality of suicide attempts, ranging from no intent to mild, moderate, or high lethality.
- **Structured Clinical Interviews:** In addition to self-report measures, structured clinical interviews were conducted to gather qualitative and clinical data from the study participants. The interviews have involved asking participants about their experiences, motivations, and feelings related to their suicide attempts.

RESULTS

Table 1: Gender-Based Sample Characteristics

	Gender	Frequency/Mean (S.D)
N	Male	45
	Female	44
	Total	89
Age	Male	33.24 (9.57)
	Female	30.43 (8)
	Total	31.85 (8.88)

This table provides an overview of the basic characteristics of the study participants, categorized by gender. It includes the mean age and standard deviation for both male and female participants.

Findings

The mean age of male participants is approximately 33.2 years, with a standard deviation of 9.57. Female participants, on average, are slightly younger, with a mean age of approximately 30.4 years and a standard deviation of 8.0.

Table 2: Distribution of Sample by Suicide Method

Method of Attempt	Gender	Frequency	Percentage
Chemical poisoning	Females	14	31.8
	Males	11	24.4
	Total	25	28.1
Cutting	Females	0	0
	Males	1	2.2
	Total	1	1.1
Fertilizer poisoning	Females	6	13.6
	Males	10	22.2
	Total	16	18
Hanging	Females	2	4.5
	Males	4	8.8
	Total	6	6.7
Medication overdose	Females	8	18.2
	Males	3	6.7
	Total	11	12.4
Rat killer paste	Females	14	31.8
	Males	16	35.5
	Total	30	33.7

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This table presents the distribution of the study sample based on the methods used in their suicide attempts. It categorizes the participants by gender and provides percentages for three categories: chemical poisoning, rat killer paste, and other methods.

Findings

- **Chemical poisoning:** This method was reported by both genders, with females accounting for 31.8% of cases and males for 24.4%.
- **Cutting:** While no females reported cutting, one male did, making up 2.2% of the total cases.
- **Fertilizer poisoning:** Females reported 13.6% of cases, and males reported 22.2% of cases.
- **Hanging:** Females accounted for 4.5% of cases, and males for 8.8%.
- **Medication overdose:** Females reported 18.2% of cases, while males reported 6.7%.
- **Rat killer paste:** Both genders reported this method, with females at 31.8% and males at 35.5%.

Above data suggests that access and affordability of certain self-harm methods may contribute to their frequent use. Notably, this aligns with findings from a 2012 study in India, where poisoning, hanging, and self-immolation were identified as the primary methods of suicide, highlighting the significance of method accessibility in self-harm (Source: Hu J, Zhang Q, Ren X 2015).

Table 3: Distribution of Sample by Reason for Suicide Attempt

This table provides insight into the reasons cited by participants for their suicide attempts.

Reason	Gender	Frequency	Percentage
Academic stress	Females	1	2.3
	Males	0	0
	Total	1	1.1
Family problem	Females	31	70.4
	Males	22	48.9
	Total	53	59.5
Family problem and financial problem	Females	1	2.3
	Males	2	4.4
	Total	3	3.3
Financial problem	Females	9	20.5
	Males	9	20.1
	Total	18	20.2
Physical health related problem	Females	0	0
	Males	1	2.2
	Total	1	1.1
Relationship problem	Females	2	4.5
	Males	5	11.1
	Total	7	7.9
Work stress	Females	0	0
	Males	6	13.3
	Total	6	6.7

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Findings:

- Family problems emerged as the most common reason for suicide attempts, with 70.4% among females and 48.9% among males.
- Family problems combined with financial problems accounted for 2.3% among females and 4.4% among males.
- Financial problems were cited as the reason for 20.5% of female attempts and 20.1% of male attempts.
- Relationship problems were noted for 4.5% of females and 11.1% of males.
- Work stress was reported for 13.3% of male attempts.

These findings align with prior research, where 80% of respondents identified family conflicts as the reason for suicide, marking it as a significant factor (Aaron R et al., 2004). Understanding family conflicts and their underlying causes is crucial, as they can lead individuals to believe that ending their life is the only solution. However the debate surrounding suicide causation whether it results from individual vulnerability or societal stressors persists. In India, suicide is considered a societal problem, with mental health issues, family conflicts, and social maladjustment being key contributors. Official data indicates that the reasons for suicide remain unknown in about 43% of cases, while illness and family problems contribute to roughly 44% (Etzersdorfer E et al., 1998). The effects of modernization in India have led to significant socioeconomic changes and increased stressors. The liberalization of the economy, privatization, job insecurity, income disparities, and evolving social roles have contributed to higher suicide rates among young adults (De Leo D; 2003). These societal shifts help explain why family and financial problems feature prominently in the current study compared to other stressors like academic pressure, work stress, relationship issues, and physical health concerns.

Table 4: Distribution of Sample by Actual Lethality

This table categorizes participants based on the actual lethality of their suicide attempts, providing insight into the severity of the attempts.

Actual Lethality	Gender	Frequency	Percentage
0 (No physical damage or very minor physical damage)	Females	0	0
	Males	0	0
	Total	0	0
1 (Minor physical damage)	Females	0	0
	Males	5	11.1
	Total	5	5.6
2 (Moderate physical damage; medical attention needed)	Females	14	31.8
	Males	4	8.9
	Total	18	20.2
3 (Moderately severe physical damage; medical hospitalization and likely intensive care required)	Females	19	43.2
	Males	6	13.3
	Total	25	28.1
4 (Severe physical damage; medical hospitalization with intensive care required)	Females	11	25
	Males	30	66.7
	Total	41	46.1
5 (Death)	Females	0	0
	Males	0	0
	Total	0	0

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Findings:

- Among females, the highest lethality score recorded was 19, indicating moderately severe physical damage, requiring medical hospitalization, and likely intensive care.
- Among males, the highest lethality score was 4, signifying severe physical damage, necessitating medical hospitalization with intensive care.

Gender plays a significant role in suicidal behavior, influenced by socially constructed roles, responsibilities, status, and power dynamics. An established pattern in suicide research reveals that women tend to make more suicide attempts than men, yet men are more likely to die as a result of their attempts. Despite this discrepancy, relatively few studies have delved into female suicidal behavior or explored the intricate relationship between gender and suicide attempts. One possible reason for this disparity may be the tendency to perceive women's suicidal behavior as manipulative or non-serious, even in cases where there is clear evidence of intent, lethality, and the need for hospitalization. Numerous studies have attempted to explain the gender gap in suicidal behavior by examining lethality. They suggest that women tend to survive suicide attempts more often than men because they tend to use less lethal methods, resulting in less severe outcomes, even when employing the same methods. Some studies have investigated the relationship between suicidal intent and gender. Theories surrounding suicide intent propose that the higher rate of suicide attempts among females, coupled with the stronger connection between suicide attempts and death in males, indicates a higher level of intent to die among males than females.

A study by Cibis A et al. in 2009 concluded that lethality varied significantly by gender across various methods. Lethality tended to increase with age, with substantial gender differences in older age groups. Men more frequently chose highly lethal methods in suicidal behavior, contributing to the overall gender differences in the lethality of suicide attempts. While males and females did not differ significantly in terms of age at the time of suicidal behavior, suicide attempts by males were generally rated as more serious, except in cases of attempted hanging. This suggests potential gender differences in the intent behind suicidal behavior. These findings enhance our understanding of the multifaceted factors contributing to gender differences in the lethality of suicidal behavior.

Table 5: Mean/Median and SD of Sample Characteristics

This table offers a summary of the mean, median, and standard deviation values for various sample characteristics.

Variable	Gender	Mean/Median	Std. Deviation (SD)
BIS - Attention	Total	11.49	1.804
	Males	11.44	2.051
	Females	11.55	1.532
BIS - Cognitive Stability	Total	8.53	1.374
	Males	8.58	1.357
	Females	8.48	1.406
BIS - Motor	Total	19.73	2.700
	Males	20.04	2.477
	Females	19.41	2.904
BIS - perseverance	Total	9.03	1.886
	Males	9.00	1.719
	Females	9.07	2.062
BIS - self control	Total	12.57	1.233

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	Males	12.89	1.283
	Females	12.25	1.102
BIS - cognitive complexity	Total	11.94	1.799
	Males	12.02	1.699
	Females	11.86	1.912
BIS - total	Total	73.3034	6.75278
	Males	73.9778	5.58606
	Females	72.6136	7.77359
Guilt Negative Behavior	Total	20.83	2.777
	Males	21.49	2.920
	Females	20.16	2.477
Guilt Repair	Total	20.73	2.378
	Males	21.31	2.601
	Females	20.14	1.984
Shame Negative Evaluation	Total	22.89	2.921
	Males	23.13	2.982
	Females	22.64	2.870
Shame Withdrawal	Total	17.38	3.845
	Males	16.60	3.695
	Females	18.18	3.872
Actual Lethality	Total	3(median)	-
	Males	4(median)	-
	Females	3(median)	-

Findings

- This table presents a comprehensive overview of various psychological variables, highlighting gender differences in means, medians, and standard deviations.

BIS - Attention, Cognitive Stability, Motor, Perseverance, Self Control, Cognitive Complexity, and Total:

- These variables relate to impulsivity and self-control. The means and medians are relatively close, indicating that the distribution of scores is not heavily skewed. Males generally have slightly higher mean scores in most of these variables compared to females. For instance, in BIS - Total, the mean for males is 73.98, while for females, it is 72.61. The standard deviations provide a measure of the spread or variability in the data. In most cases, the standard deviations are relatively low, suggesting that scores are clustered around the mean.

Guilt Negative Behavior and Guilt Repair:

- These variables assess guilt and coping with guilt. Males have a slightly higher mean in both Guilt Negative Behavior (21.49 vs. 20.16) and Guilt Repair (21.31 vs. 20.14) compared to females. The standard deviations are relatively moderate, indicating some variability in responses.

Shame Negative Evaluation and Shame Withdrawal:

- These variables measure experiences related to shame. Males have a slightly higher mean in Shame Negative Evaluation (23.13 vs. 22.64), while females have a slightly higher mean in Shame Withdrawal (18.18 vs. 16.60). The standard deviations in these variables are relatively high, suggesting a wider range of responses.

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Actual Lethality:

- The table provides median values without specifying the units or scale of actual lethality. Both males and females have a median score of 3, suggesting that, on average, both genders may experience similar levels of actual lethality. However, without context, it is challenging to interpret these values.

Table 6: Gender Differences in Guilt, Shame, Impulsivity, and Suicide Lethality

This table displays the results of statistical tests examining gender differences in guilt, shame, impulsivity, and suicide lethality dimensions.

Variable	't value'	df	Sig. (2-tailed)
BIS - Attention	-.263	87	.793
BIS - Cognitive Stability	.343	87	.732
BIS - Motor	1.111	87	.269
BIS - perseverance	-.170	87	.866
BIS - self control	2.517	87	.014*
BIS - cognitive complexity	.414	87	.680
BIS - total	.949	77.961	.346
Guilt Negative Behavior	2.314	87	.023*
Guilt Repair	2.399	82.166	.019*
Shame Negative Evaluation	.801	87	.425
Shame Withdrawal	-1.972	87	.052

Findings:

Significant Gender Differences:

- There are statistically significant gender differences in three variables: BIS-Self Control, Guilt-Negative Behavior Evaluation, and Guilt-Repair, all at a 0.05 level of significance (*). As a result, Hypothesis 1a, 1b, and 3e are accepted. Hypothesis 2a, 2b, 3a, 3b, 3c, 3d, and 3f are rejected.

Non-Significant Gender Differences:

- No statistically significant gender differences were found in the following variables: BIS-Total, BIS-Attention, BIS-Cognitive Stability, BIS-Cognitive Complexity, BIS-Motor, BIS-Perseverance, Shame-Negative Evaluation, and Shame-Withdrawal.

The results indicate that there is a relationship between impulsivity and guilt-shame dimensions among men and women who have attempted suicide, particularly in the dimensions of self-control, guilt-negative behavior evaluation, and guilt repair. Understanding these gender-specific differences in impulsivity and guilt-shame can be crucial, especially when underlying behaviors differ between men and women.

The current study highlights that impulsivity differs between genders, with men displaying more impulsive choices when real rewards are involved, while women tend to make more impulsive choices when rewards are hypothetical.

Impulsivity and Suicidal Behavior:

Impulsivity is recognized as a risk factor for suicide, facilitating the transition from suicidal thoughts to suicide attempts. Studies suggest that individuals who have attempted suicide or experienced suicidal ideation exhibit higher impulsivity scores compared to those who have

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never been suicidal. Impulsivity is moderately elevated in individuals with a history of suicidality (thoughts or behavior).

Shame and Guilt:

Shame is associated with negative self-evaluation, leading individuals to attribute transgressions to personal character flaws. In contrast, guilt arises from the belief that transgressions result from behavioral errors that can be corrected. Shame-proneness often leads to maladaptive avoidance or withdrawal behaviors, while guilt-proneness is associated with adaptive approach behaviors, such as taking reparative actions.

The Role of Impulsivity:

Impulsivity is believed to have a distal relationship with suicidal behavior by increasing exposure to painful and provocative events. Studies have shown that painful and provocative events mediate the relationship between impulsivity and suicidal behavior. In essence, impulsivity contributes to a lifestyle in which individuals are more likely to experience painful and provocative events, thereby influencing suicidal behavior.

Intent and Lethality:

Dr. Beck and colleagues have developed a nomenclature for suicidal behaviors, distinguishing suicidal ideation, suicide attempts, and completed suicide. The belief in the lethality of the chosen method is significantly correlated with suicidal intent, while intent scores do not necessarily correlate highly with the medical lethality of suicide attempts.

Table 7: Effect Size for Significant Gender Differences

This table provides effect sizes (Cohen's d) for variables showing significant gender differences, helping to quantify the practical significance of these differences.

S.no	Variable	Mean difference (male mean- female mean)	Cohen's d	Effect size
1	BIS-Self control	0.64	0.54	Medium effect size
2	Guilt- Negative behaviour evaluation	1.33	0.49	Medium effect size
3	Guilt – Repair	1.17	0.51	Medium effect size

Findings:

From the information presented in the table, it is evident that males who have attempted suicide scored significantly higher than females who have attempted suicide in the following variables: BIS-Self Control, Guilt-Negative Behavior Evaluation, and Guilt-Repair. Impulsivity is a key factor highlighted for its role in facilitating suicidal actions among individuals with suicidal ideation. Mann and colleagues have developed a clinical model of suicidal behavior, suggesting that impulsivity makes individuals "more likely to act on suicidal feelings." Similarly, Bryan and Rudd emphasize that impulsivity "may actually be a more significant indicator of a suicide attempt than the presence of a specific suicide plan." Impulsivity has been widely recognized as a risk factor or warning sign for suicide. The American Association of Suicidology includes impulsivity as both a chronic and an acute suicide risk factor. Impulsivity is also emphasized by the American Foundation for Suicide

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Prevention and the Substance Abuse and Mental Health Services Administration. Drawing from evolutionary, criminological, developmental, and personality theories, researchers have predicted that sex differences would be most pronounced in risky activities. Men tend to demonstrate greater sensation-seeking, greater sensitivity to reward, and lower sensitivity to punishment, with a male advantage in effortful control. In a comprehensive study, researchers analyzed 741 effect sizes from 277 studies, encompassing psychometric and behavioral measures. They found that women consistently exhibited greater sensitivity to punishment, while men did not show significantly greater sensitivity to reward. Men did, however, display higher sensation-seeking on questionnaire measures and in behavioral risk-taking tasks. Although questionnaire measures of deficits in effortful control showed a very modest effect size in favor of males, no significant sex differences were found on delay-discounting or executive function tasks. The study concluded that "the results indicate a stronger sex difference in motivational rather than effortful or executive forms of behavior control. Specifically, they support evolutionary and biological theories of risk-taking based on sex differences in punishment sensitivity."

Guilt and Shame, both aversive and intense emotions, are regarded as potential sources of psychological pain, with some theorists arguing that shame plays a central role in suicidal behaviors. Theoretically, shame can be described as an aversive affective state coupled with a negative evaluation of the entire self. Shame is often experienced as a more distressing and devastating emotion than guilt because guilt involves a negative self-evaluation specific to particular behaviors, which can be alleviated through apology or reparative actions. In contrast, shame typically leads to a desire to hide or escape.

In a study by Tangney and Dearing (2002), shame-proneness in fifth grade predicted suicide attempts in early adulthood. Shame has been linked to self-injurious behavior, whether or not suicide intent is involved. The findings of the present study indicate that males tend to experience more shame and guilt than females. Additionally, males are more inclined to engage in negative self-evaluation compared to females, and they are also more likely to undertake acts aimed at repairing feelings of guilt.

Table 8: Gender Differences in Actual Lethality

This table presents the results of a statistical test examining gender differences in the actual lethality of suicide attempts.

	Gender	N	Mean Rank	Sum of Ranks	Mann-Whitney U	Sig (2 tail)	Ranked Biserial coefficient
Actual Lethality	Male	45	52.42	2359.00	656.00	0.003**	0.34 (moderate effect size)
	Female	44	37.41	1646.00			
	Total	89					

Findings:

- A significant gender difference was observed ($p < 0.01^{**}$), with males employing more lethal methods in their suicide attempts.
- The moderate effect size (0.34) underscores the practical significance of this gender difference.
- The table above reveals a significant difference in Actual Lethality between males and females who have attempted suicide, as determined by the Mann-Whitney U test. Males exhibit higher actual lethality, as indicated by their mean rank (2359.00). The

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effect size (0.34) of this gender difference in Actual Lethality can be considered moderate according to the Glass ranked biserial formula. As a result, hypothesis 4 is accepted. Numerous studies have consistently found that males tend to engage in more lethal suicide attempts compared to females. Several factors influence the lethality of a suicidal act, often independently of the choice of more or less lethal methods. One such factor is the social and communicative context surrounding the suicidal act. Men's reluctance to seek help, communicate their acute crisis, and their higher social isolation may reduce the likelihood of receiving timely assistance, especially after an acute intoxication (Cibis A et al; 2012). Additionally, the involvement of alcohol or drug consumption is more common in males than in females (Bönisch S et al; 2010), which can increase the lethality of suicide attempts, particularly in individuals with mood disorders (Sher L et al; 2009). Generally, males tend to combine suicide methods more often than females (Töro K, Pollak S; 2009). Factors that influence lethality through the choice of a more lethal suicide method include social acceptability, model learning (cognitive availability), and ease of access to or technical proficiency in the chosen suicide method (Ajdacic-Gross et al; 2008). It is expected that males have easier access to knowledge and firearms, which can lead to more lethal outcomes. The technical skills required for hanging may also deter females from choosing this highly lethal method (Elnour AA, Harrison J; 2008). Furthermore, it is suggested that women may be more concerned about their physical appearance and take measures to ensure that their body and face are not severely injured, which may contribute to their preference for self-poisoning (Callanan V, Davis M; 2012). Other factors that influence lethality include the age of the individual and their intent to die. Higher age is generally associated with a more lethal outcome in suicidal acts and may also impact the choice of the suicidal method. Gender differences may exist in the decisiveness to die, leading to a stronger intentionality behind suicidal acts. This may explain both the choice of more lethal methods and the overall higher lethality in males. Additionally, there may be gender differences in the dynamics of the suicidal process, such as higher impulsivity in suicidal acts among males.

Table 9: Correlation Between Actual Lethality and Dependent Variables

This table explores the relationships between actual lethality and various dependent variables, focusing on shame withdrawal.

DV	Actual lethality
BIS-Attention	-.030
BIS-Cognitive Stability	.057
BIS-Motor	-.067
BIS-Perseverance	-.020
BIS-Self Control	.112
BIS-Cognitive complexity	.049
BIS total	-.012
Guilt-Negative Behavior	.065
Guilt-Repair	-.081
Shame-Negative Evaluation	-.156
Shame-Withdrawal	-.226*

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Findings:

- A significant positive relationship was found between suicide lethality and shame withdrawal ($p = 0.05^*$).
- This suggests that individuals who exhibit shame withdrawal behaviors tend to engage in more lethal suicide attempts.
- While no significant relationships were observed for other variables, the link between shame withdrawal and lethality highlights the role of shame-related emotions in suicide attempts.

The information presented in the table indicates that there is no significant relationship between the variable 'Actual Lethality' and the following variables: BIS-Attention, BIS-Cognitive Stability, BIS-Motor, BIS-Perseverance, BIS-Self Control, BIS-Cognitive Complexity, BIS-Total, Guilt-Negative Behavior, Guilt-Repair, and Shame-Negative Evaluation. Consequently, hypotheses 5a, 5b, 5c, 5d, 5e, 5f, 5g, 6a, 6b, and 7a are rejected. However, a significant relationship is observed between Actual Lethality and Shame-Withdrawal. Thus, hypothesis 7b is accepted.

Shame, characterized by its aversive and often intense nature, can be a source of psychological distress, and some theorists argue that shame plays a central role in suicidal behaviors. Qualitative studies exploring patient experiences have suggested that shame reactions are common following a suicide attempt. For instance, in an interview study conducted by a research group, thirteen out of eighteen individuals who had attempted suicide spontaneously described experiencing shame reactions after their suicide attempt or during their subsequent hospitalization. These shame reactions included feelings of stupidity and hesitance in seeking help.

Feelings of shame typically arise in situations of perceived failure. It is understandable that individuals may experience transient feelings of shame, known as state shame, in relation to a suicide attempt—for instance, for feeling unable to cope with life, violating the societal prohibition against suicide, or failing to end their own life. Such feelings of shame may also stem from circumstances associated with being a psychiatric patient. In the present study, it was found that males tend to engage in shame withdrawal behaviors more frequently compared to females.

Gender Differences in Guilt, Shame, Impulsivity, and Suicide Lethality

The current study uncovered significant gender differences in several critical dimensions related to guilt, shame, impulsivity, and suicide lethality.

Guilt Dimensions:

- **Guilt-Negative Behavior Evaluation:** Although overall guilt proneness levels did not significantly differ between genders, a notable gender difference emerged in the dimension of guilt associated with negative behavior evaluation. Males displayed higher scores ($p = 0.023^*$), indicating a greater tendency to evaluate their behavior negatively compared to females. This finding suggests that males may be more inclined to perceive their actions as morally wrong following a suicide attempt.
- **Guilt-Repair:** Similar to guilt-negative behavior evaluation, males scored significantly higher ($p = 0.019^*$) in guilt-repair. This dimension reflects a greater

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effort to repair relationships or situations following guilt-inducing behaviors. Consequently, men may be more motivated to make amends after a suicide attempt.

Shame Dimensions:

- **Shame-Negative Evaluation and Shame Withdrawal:** No significant gender differences were observed in shame proneness, including shame-negative evaluation and shame withdrawal. This suggests that both males and females exhibit comparable levels of self-criticism and the desire to withdraw from others following a suicide attempt.

Impulsivity Dimensions:

- **Self-Control:** Our study revealed a significant gender difference in self-control ($p = 0.014^*$), with males displaying poorer self-control compared to females. This result implies that impulsivity, particularly in terms of self-control, may play a distinct role in male suicide attempters. Deficiencies in self-control could contribute to their impulsive decision-making processes.

Suicide Lethality:

- Our investigation highlighted a significant gender disparity in suicide lethality ($p < 0.01^{**}$), with males employing more lethal methods in suicide attempts compared to females. This finding aligns with existing research indicating that males tend to use more aggressive and dangerous means in their suicide attempts, potentially resulting in higher fatality rates. The moderate effect size (0.34) emphasizes the practical significance of this gender difference in suicide lethality.

Correlations Between Variables

Current study examined the relationships between guilt, shame, impulsivity, and suicide lethality:

- **Suicide Lethality and Shame Withdrawal:** A significant relationship was found between suicide lethality and shame withdrawal ($p = 0.05^*$). This implies that individuals who exhibit shame withdrawal behaviors tend to engage in more lethal suicide attempts. Shame withdrawal, characterized by social isolation and avoidance, may contribute to an increased risk of fatal outcomes.

However, it is noteworthy that no other significant relationships were observed between suicide lethality and various dimensions of impulsivity, guilt, and shame.

DISCUSSION

These findings collectively underscore the complexity of factors contributing to suicide attempts, particularly in the context of gender-based differences. The higher levels of self-control deficits and the utilization of more lethal methods in male suicide attempts suggest the need for gender-specific suicide prevention strategies. The significant relationship between shame withdrawal and suicide lethality underscores the importance of addressing shame-related emotions in suicide intervention efforts. Shame, as a multifaceted emotion, can manifest differently in suicide attempters and may have varying degrees of impact on the lethality of attempts.

CONCLUSION

In conclusion, this study has illuminated critical gender-based differences in guilt, shame, impulsivity, and suicide lethality among suicide attempters in Chennai, India. These findings underscore the necessity for tailored interventions that consider male-specific patterns of self-control and the use of more lethal means. Moreover, the role of shame and its withdrawal dimension in suicide lethality highlights the importance of addressing shame-related emotions in suicide prevention strategies. By gaining a deeper understanding of these complex dynamics, healthcare professionals and policymakers can develop more effective suicide prevention and intervention programs that take into account the unique needs of individuals based on their gender and emotional profiles. These insights are vital in the ongoing efforts to reduce the burden of suicide in Chennai and beyond.

Limitations

The study's limitations stem from various factors. Firstly, the study's samples were exclusively drawn from patients admitted to Rajiv Gandhi Government General Hospital, Chennai making it challenging to generalize the findings to the broader community. Secondly, the administration of three questionnaires proved to be exhaustive and time-consuming, particularly considering that many patients were on ventilators, which added an extra layer of complexity. Thirdly, while the sample size of 30 patients per group is typically considered sufficient to detect statistically significant differences, a larger sample size would have been preferable for greater robustness. Unfortunately, the determined sample size of 370 could not be achieved due to the global pandemic and associated lockdowns in the city. Additionally, all assessments were conducted by a single investigator, introducing the potential for interviewer bias.

Implications Of the Study

Based on the current study findings, it is recommended that future research and clinical practice focus on screening individuals for impulsivity levels and implementing targeted interventions. These interventions should address anger management, self-control, cognitive complexity, as well as psychotherapy techniques dealing with guilt and shame. Evaluating these interventions in modular formats using experimental methods, like pre-test and post-test assessments, is advisable. Additionally, incorporating personality questionnaires to understand personality traits and their relationships with impulsivity, guilt, shame, and lethality could provide valuable insights. Lastly, assessing overall mental health and mental health issues through a dedicated questionnaire would enhance the comprehensive understanding of individuals mental well-being. These considerations will contribute to refining future research and developing more effective intervention and support strategies.

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Conflict of Interest

The author(s) declared no conflict of interest.

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